

Weekend Health and Permission Form

East Ohio Conference of the United Methodist Church
Camp and Retreat Ministries

Participant's Name _____ Birthday ____/____/____
Mo Day Year

Parent(s) Name(s) (if participant is a minor) _____

Street Address _____ Phone (day) (____) _____

City, State, Zip _____ Phone (eve) (____) _____

Social Security Number _____

Emergency Contact _____ Phone (____) _____

Second Emergency Contact _____ Phone (____) _____

Is the participant covered by family medical/hospital insurance? ___ yes ___ no

If yes, indicate carrier or plan name _____ Group Number _____

Family Physician _____ Phone (____) _____

Does the participant have any allergies? ___ yes ___ no

If yes, please list.

Are any of these allergies life-threatening? ___ yes ___ no

If yes, please note the reaction.

Are there any other health conditions that the leadership should be aware of? ___ yes ___ no

If yes, please explain.

Will the participant bring any medications with them (including inhalers and bee sting kits)? ___ yes ___ no

Please list.

AUTHORIZATIONS:

I am/we are in favor of the above person attending an event and participating in all activities unless otherwise specified. As parent(s), legal guardians, or as an adult participant we/I accept the conditions stated, including the release of the Conference and Camp Management/staff from liability in case of accident/injury. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes for the participant named on this health form.

IN CASE OF MEDICAL ILLNESS OR INJURY, I hereby give permission to the camp to obtain proper medical care for the participant named on this health form. I authorize the camp nurse or certified first aid care provider to give first aid care, medicine, or treatment as ordered by the camp physician. **Initials** _____

IN CASE OF MEDICAL EMERGENCY, or in the event that the above named participant needs medical care beyond camp facilities, I understand that every effort to reach the emergency contact(s) listed will be made. If no one can be reached, I hereby give permission to the attending physician to hospitalize, secure proper treatment for, order injection, anesthesia or surgery as necessary for the participant named on this health form. **Initials** _____

(In the case of a minor) I give permission for the above named participant to participate in off-site travel, under the supervision of the event leadership, as part of the program for the event for which she/he is registered. **Initials** _____

MEDIA RELEASE: I authorize the use of photographs or video in promotional materials. **Initials** _____

Signature: _____ **Date:** _____